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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KATHLEEN KAY BELL** **Post Office Box 190** **Jefferson, OR 97352** **Registered Nurse License No. 562487** Respondent.	Case No. 2011-794 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about January 21, 2000, the Board of Registered Nursing issued Registered Nurse License Number 562487 to Kathleen Kay Bell (Respondent). The Registered Nurse License expired on October 31, 2009, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action."

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Out of State Discipline)
(Bus. & Prof. Code § 2761, subd. (a)(4))

9. Respondent has subjected her registered nurse license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about April 23, 2009, in a disciplinary action before the Board of Nursing for the State of Oregon (Oregon Board), the Oregon Board entered a Final Order approving the Stipulation for Probation with Conditions between Respondent and the Oregon Board. The Stipulation placed Respondent's license on probation for 24 months under various terms and conditions. The Stipulation required Respondent to: (1) work a minimum of 80 hours per month as a registered nurse in Oregon; (2) not violate the Nurse Practice Act; (3) notify the Oregon Board, in writing, of any change of address or employment during the probation period; (4) report to designated staff from the Oregon Board once a month for the first six months of probation; (5) submit quarterly written reports to the Oregon Board; (6) inform current and prospective employers of the probationary status of her license; (7) work only in settings where the Nurse Executive agrees to submit quarterly written evaluations regarding Respondent's work performance; (8) work only in settings pre-approved by the Oregon Board; (9) work only in a setting where she is under constant supervision; (10) not work for a temporary staffing agency during the probationary period unless such agency provides written confirmation to the Oregon Board that Respondent will not be assigned to multiple facilities; (11) not work the "night shift" or "over-nights" during the probationary period; (12) not be employed by a home health agency, visiting nurse agency, or in a community based setting during the probationary period;

(13) submit to random urine drug screens upon request during the probationary period; (14) immediately report any arrest, citation or conviction to the Oregon Board; (15) cease performing duties as a registered nurse upon the request of her probation coordinator; and (16) complete an Oregon Board-approved re-entry or refresher program as specified in the Nurse Practice Act. Respondent signed the Stipulation for Probation with Conditions on or about April 8, 2009.

10. The underlying conduct supporting the Oregon Board's disciplinary action is that in or about February 2009, the Oregon Board received a complaint stating that Respondent had failed to: (1) properly respond to an emergency situation; (2) ensure the safety of a client with a tracheotomy; and (3) properly supervise a nursing assistant. Upon receipt of the complaint, the Oregon Board opened an investigation which revealed that on or about January 25, 2009, Respondent was employed by a staffing agency and was assigned to work as the charge nurse at a skilled nursing unit from 7:00 p.m. until 7:30 a.m. At approximately 10:00 p.m., another nurse's shift ended and Respondent assumed the care of that nurse's patients. At some point that evening, Respondent was asked to check on a patient who had had a tracheotomy, was quadriplegic, and had recently returned from the hospital following a case of pneumonia. Respondent was told that "something was wrong" with the patient. Respondent went to the patient's room and was followed by a certified nursing assistant (CNA). Although the patient was in distress by all accounts, Respondent did not intervene. Respondent did not call Code 99[1], did not assess the patient's respiratory status, and did not request help from the other nurse on duty. The CNA finally removed the inner cannula from the patient, suctioned the airway, and relieved the patient's mucous plug, which was causing the distress. Respondent did not stop the

[1] In some hospitals "Code Blue" has been changed to "Code 99." Code 99 is generally used to indicate a patient requiring immediate resuscitation, most often as the result of a cardiac arrest. Code 99 may also be used as a radio call to indicate that a patient en route to the hospital requires resuscitation.

CNA from taking this action despite the fact that such intervention was not within the CNA's scope of duties. Respondent later admitted in an interview with Oregon Board staff that she did not know how to respond to the emergency situation. While she fully recognized that she did not have the skill or experience to care for the patient if another emergency occurred that night, Respondent failed to take any action to ensure the safety of the patient. Respondent further admitted that she "padded" her skill ratings on nurse self-evaluation forms in response to questions relating to tracheotomy suctioning and care to improve her chances of getting assignments.

11. The Oregon Board also discovered that Respondent had been placed on several facility's "do not use" lists due to her poor practice standards, such as leaving medication carts unlocked and unmonitored, providing poor assessment of residents, exercising poor nursing judgment, confusion during medication passes, and irregularities with narcotic management. Respondent admitted to the Oregon Board that her assessment of patients consisted of talking to the patient and "observing" them. The Oregon Board also found that Respondent had either resigned or been terminated from all of her permanent positions and had travelling contracts cancelled weeks early due to her lack of skill. The Oregon Board concluded that Respondent showed poor judgment, little or no nursing intuition, poor assessment skills, and a lack of insight into technology and current trends in nursing care.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Out of State Discipline)
(Bus. & Prof. Code § 2761, subd. (a)(4))

12. Complainant realleges the allegations contained in paragraphs 9 through 11 above, and incorporates them as if fully set forth.

13. Respondent has subjected her registered nurse license to disciplinary action under Code section 2761, subdivision (a)(4), in that on or about September 16, 2009, in a disciplinary action before the Oregon Board, the Oregon Board entered a Final Order accepting the Stipulation

for Voluntary Surrender of Registered Nurse License. The Stipulation for Voluntary Surrender required that Respondent wait three years until applying for reinstatement, at which time she would be required to present evidence to the Oregon Board showing her ability to safely practice nursing.

14. The underlying conduct supporting the Oregon Board's disciplinary action is that on or about June 24, 2009, after the Oregon Board approved the Stipulation for Probation with Conditions, Respondent notified the Oregon Board that she wished to remove herself from nursing practice. Respondent signed the Stipulation for Voluntary Surrender on or about July 5, 2009.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 562487, issued to Kathleen Kay Bell;

2. Ordering Kathleen Kay Bell to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: March 22, 2011

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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